

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: <input type="checkbox"/> HCP <input type="checkbox"/> IE <input type="checkbox"/> IC		Response Timely Filed? (X) Yes <input type="checkbox"/> No	
Requestor's Name and Address Metroplex Diagnostics 200 Wynnewood Village Dallas, TX 75224		MDR Tracking No.: M4-04-0641-01	
		TWCC No.:	
		Injured Employee's Name:	
Respondent's Name and Address Box# 12 Texas Association of School Boards Risk Management		Date of Injury:	
		Employer's Name: Cypress Fairbanks ISD	
		Insurance Carrier's No.: 00025-098-102-2153458	

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
3/18/03	3/18/03	95900-27 x 4	179.20	134.40
		95904-27 x 4	179.20	179.20
		95935-27 x 6	222.60	111.30
Total Amount in Dispute			\$581.00	-
Total Amount Due				\$424.90

PART III: REQUESTOR'S POSITION SUMMARY

Carrier is disputing the services stating not appropriate health care provider. This denial is not appropriate, as the Texas Board of Chiropractic Examiners has ruled that NCV Studies were part of the scope and practice of a licensed DC in Texas. These tests include needle EMG, somato-sensory evoked potential and H reflex studies.

PART IV: RESPONDENT'S POSITION SUMMARY

It is TASB's position that surface testing is inconclusive and unnecessary treatment. Ruling out radiculopathy using NCV, DEP and EMG tests together are not within the scope of a chiropractor as shown by the SOAH Decision. The AG's opinion states that the "...legislature intended the use of needles for the purpose other than drawing of blood for diagnostic purposes to be excluded from the scope of chiropractic." (Denial code K – Services billed are not within the course/scope of expertise listed.)

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The SOAH decision provided by the Respondent was specific discussion over reimbursement of an EMG performed by a chiropractor. There are no EMG charges in this medical dispute; therefore, the SOAH decision offers no relevance to this case.

The January 25, 2002 letter from the Texas Board of Chiropractic Examiners (TCBE) signed by the Board's President and Technical Standards Committee Chairman, states, "On July 24, 1998 this Board ruled that nerve conduction studies were part of the scope of practice of a licensed DC in Texas. These tests would include all nerve conduction studies such as needle EMG, somato-sensory evoked potential studies, visual evoked potentials, H reflex, amplitude and latency studies.

'...Although it is not a requirement, it is the Board's opinion and recommendation that a practitioner exercises "due diligence" when they have obtained and completed a 120-hour course in electrodiagnostics offered at CCE accredited chiropractic colleges, or they have received status as an ACA Diplomate in Neurology.'

As indicated in TCBE's letter, their recommendation for this special training is not a requirement. Consequently, the Commission cannot overrule the TCBE's recommendation and deny reimbursement for lack of this special training in the disputed nerve studies. The Commission does not agree with the Respondent's denial reasons for the disputed services.

The Respondent did question medical necessity but according to the EOB this question is only applicable to one unit out of the four units billed for 95900-27. The Requestor has since provided a letter withdrawing this charge for \$44.80 and therefore medical necessity is no longer in dispute. Reimbursement is recommended for three units of 95900-27.

Review of the documentation shows the injured worker complained of left hip pain. Sensory studies (95904) were done to the sural and peroneal nerves and motor studies (95900) were done to the tibial and peroneal nerves of the bilateral lower extremities. The "F" and "H" wave studies (95935) were conducted bilaterally.

According to the 1996 MFG Medicine Ground Rule IV. Nerve Studies, B. Reflex Studies, 2, if performed bilaterally "H" studies may be per extremity. However, the "F" studies, separate reimbursement may be allowed per extremity if both extremities were affected by the compensable injury. Since only the left hip was affected, the comparison study of the right lower extremity is not separately reimbursable. Consequently, only three units of 95935-27 are recommended.

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of **\$424.90**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Patti Lanfranco

June 30, 2005

Authorized Signature

Typed Name

Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings, within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____